ASSISTANCE REQUEST SURVEY

Arizona Public Service Company has established "Operation Outreach" as a means of educating and informing residents about nuclear power in general and the Palo Verde Nuclear Generating Station specifically. They are working closely with federal, state and county emergency management agencies to provide for your health and safety.

Maricopa County Department of Emergency Management will use this information in evaluating needs and identifying potential emergency transportation and shelter requirements. Every effort will be made to support requested assistance; however, this should not replace individual preparedness and planning. This information will be kept confidential and only used by emergency response agencies. Please complete this survey whether assistance is needed or not.

If you have questions or would like assistance to complete this survey please contact (602) 273-1411, AZ Relay Service 711 or 602-244-1409(TTY). You can also fill out this survey on-line at www.maricopa.gov/Emerg_Mgt/AssistanceRequest/

"PLEASE PRINT"

NAME(S) OF PERSONS LIVING IN HOUSEHOLD (Please include first and last names)	**AGE**	**Assistance Needed?**
		☐
		☐
		☐
		☐
		☐
		☐
		☐

Residential Address: House number: _____ Direction: ___ Street: _____Apt.:____

City: _____ State: _____ Zip Code: _____

Mailing address (if different): _____

City: _____ State: _____ Zip Code: _____

Telephone Number(s): Residence: _____

Cellular(s):_____Text Capable: ☐ Yes☐ No

☐ Yes ☐ No 1. Would you, or any member of your family, (including children or elderly home unattended during the day), require additional assistance to leave your home on short notice? Please check ALL that apply that best describe any disability or medical condition that affects your mobility.

- ☐ Use a Walker or Cane (Necessary for Mobility)
- ☐ Use a Wheelchair (Necessary for Mobility)
- ☐ Unable to be out of Bed (Have no mobility)
- ☐ Use a Ventilator/Respirator (Needed to sustain life)
- ☐ Use Portable Oxygen Equipment (Needed to breathe)
  - ☐ Tank
  - ☐ Concentrator
- ☐ Require Electricity For Life Sustaining Equipment (Needed to operate any life sustaining devices)
- ☐ Service Animal

Please note any other assistance you would require: _____

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☐ Yes ☐ No 2. Please check ALL that apply that best describe any disability or medical conditions.

- ☐ Deaf/Hard of Hearing Impairment
- ☐ Blind/Visual Impairment
- ☐ Cognitive
- ☐ Autism Spectrum Disorder
- ☐ Seizure Disorder
- ☐ Speech Disability
- ☐ Alzheimer's/Dementia
- ☐ Psychiatric Disability
- ☐ Non-Verbal Communication
- ☐ Other: _____

☐ Yes ☐ No 3. Will you need transportation during an emergency?

- ☐ Accessible Transportation?

☐ Yes ☐ No 4. Do you have pets? (If so, how many and what type?)

_____